Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Cara House
Centre ID:	OSV-0005199
Centre county:	Laois
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Nua Healthcare Services Unlimited Company
Provider Nominee:	Danika McCartney
Lead inspector:	Louise Renwick
Support inspector(s):	Maureen Burns Rees
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
31 January 2017 11:00	31 January 2017 18:30
01 February 2017 10:00	01 February 2017 16:00

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

This centre had one previous inspection in September 2015 after the provider had applied to register it as a designated centre. At the time of the last inspection the centre was not yet operational but was found to be compliant with the Regulations in respect of their proposed systems, plans, management and staffing.

This inspection was the first inspection on the centre with full resident capacity and a full staff team in place.

Description of the service:

The provider's written statement of purpose dated January 2017 describes this centre as delivering services under the headings of autism and intellectual disabilities. The statement of purpose outlined that it provided 24 hour care to children and adults both male and female aged 16-30 years.

On the day of inspection the centre was providing care and support to six female residents from 16-27 years in respect of their disabilities and/ or autism. Inspectors

found that residents were being supported with mental health needs. The centre also provided support to manage behaviours of concern such as aggression, violence and self harm.

How we gathered our evidence:

Inspectors met and spoke with the person in charge, acting regional manager, one deputy team leader and four staff members. Inspectors spoke with two residents and spent time with another resident who communicated non-verbally. Inspectors reviewed documentation such as assessments, personal plans, daily logs, accident and incident forms and policies and procedures. Inspectors also reviewed a sample of staff files.

Overall findings:

Inspectors identified both good practice and areas in need of improvement in the designated centre. This report identifies 13 actions in need of address by the provider and person in charge to improve the safety and quality of care of residents.

Residents' healthcare needs, medication management, the statement of purpose and workforce were found to be substantially compliant and in general positive outcomes were found for residents under these headings. Good practice was also identified in regards to residents' social care needs being encouraged and met.

Some examples of good practices were noted such as:

- Staff members were advocating for young residents' right to education locally
- Good supports were in place to keep residents connected with their families and visit home frequently
- There was a range of day service options available for residents and residents were supported to find paid employment
- The provider had put in place high levels and consistent levels of staffing
- The premises met residents' needs. All residents had their own private bedrooms, a spare room upstairs had been changed into a multisensory room for residents to enjoy, some residents had animals in the garden as pets.

Inspectors identified two areas in need of significant improvement:

- Safeguarding
- Governance and management

Areas in need of further improvement:

- Health and safety and risk management
- Social care needs in respect of assessments and plans

Inspectors were seriously concerned regarding the safeguarding mechanisms in the

designated centre and the provider and person in charge's ability to keep residents safe. An allegation of physical abuse by a staff member had not been appropriately managed or investigated at the time of it occurring. Because the person in charge had not taken appropriate action this resulted in further incidents of concern occurring. Incidents of peer to peer abuse continued to occur and risks were not being fully and appropriately managed.

All findings are outlined within the body of the report and the areas for improvement included in the action plan at the end.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors found that residents living in the centre were encouraged and supported to be social and active members of their community. However, some improvements were required in relation to assessments and plans.

There was a range of day services available to resident to attend if they wished, and inspectors found that some residents were supported to obtain and maintain paid employment. The person in charge and staff team were actively seeking opportunities for residents to become more involved in the community. For example, raising funds for local events, seeking education locally and availing of local amenities. Staffing and transport available ensured residents could access the community at times that suited their daily planner and in line with their needs in this regard.

In relation to the assessment and planning for residents' needs, improvements were required with respect to new admissions. While information was gathered prior to a move, and residents had the opportunity to visit the centre in advance, there was a lack of comprehensive assessment carried out prior to their admission. An initial needs assessment was carried out to gather information, but this was not comprehensive enough. While the provider ensured a 12 week assessment period and access to a range of Multidisciplinary Team (MDT) professionals, the full assessment and recommendations were not sought prior to the move.

Assessments conducted for residents over the initial 12 week period in general resulted in a psychiatric assessment report, a psychological report, a functional assessment by behaviour specialist and a social report conducted by staff in the centre. There was also

an ability and skills assessment done in the centre by staff. Residents' identified goals and outcomes to work towards and these were reviewed monthly with staff. Inspectors found that these goals were actively worked on and residents were encouraged to be as independent as possible. For example, preparing meals, seeking employment.

Residents had quarterly MDT meetings to review all professional inputs, but for new residents while individual assessments had taken place, there was a lack of correlation of all professional opinions prior to this meeting to ensure a clear personal plan outlining residents support needs was put in place as based on their assessed needs.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors identified areas in need of improvement under this outcome to ensure the promotion of the health and safety of residents, staff and visitors.

Areas of good practice were noted in relation to the systems in place for the management of the risk of fire and infection control.

Policies and practices in relation to infection control were found to be adequate, with systems in place to promote hand hygiene, safe preparation of food and general good practice regarding the prevention of infection or outbreak. Training was provided to staff in relation to this also.

Inspectors reviewed the systems, policies, training and practices in relation to fire safety and found them to be safe. There was a fire detection and alarm system in place, emergency lighting, fire fighting equipment and evidence that these had been checked and serviced routinely by a relevant professional. Fire drills had taken place at various times of the day and records were maintained. Inspectors spoke with the person in charge regarding expanding the documentation around this, as the records did not always show who took part and how long the evacuation took to complete. Staff had completed both online fire safety training, along with face to face training with a relevant professional on fire prevention and the use of fire fighting equipment. There was an assembly point available and evidence of a written fire plan on display. Exits were observed as being unobstructed and there were fire doors in the building. Residents were encouraged to smoke outside in a designated smoking area and

extinguish their cigarettes safely. This was all supporting the safe management of the risk of fire in the designated centre.

Inspectors found that risk management practices required improvement. While there were procedures for assessing risks, it was unclear at what level a risk was accepted or required further action. For example, an impact assessment completed prior to admission for a resident outlined a known risk to fellow residents from harm or abuse. Incident records and notifications submitted showed that negative interactions were occurring as predicted even with the control measures and staffing in place. Inspectors noted an amendment to the staffing levels at night in response to a new resident moving in which was a positive action taken by the person in charge. However, due to the inadequate management of risk, incidents were still occurring that were affecting residents. For example, since December there had been 20 incidents between peers ranging from verbal interactions, threatening behaviour and physical assault. Similarly, inspectors were not assured that all control measures were being fully put in place by staff to reduce the likelihood of incident. For example, a resident obtaining access to a lighter when there was a known risk of fire setting.

There was a disconnect between the review of incidents, and the assessment of the risks associated with them. For example, incidents were rated for their severity if injury actually occurred, but there was no expectation on staff or management for assessing the likelihood of it happening again. This resulted in the absence of additional control measures being put in place to alleviate or reduce them and wasn't ensuring a risk based approach to prevent re-occurrence. Escalation pathways were inhibited due to this manner in which incidents were reviewed and rated. For example, a near miss not being escalated as no actual harm occurred.

Inspectors noted that any accident or injury was recorded in the designated centre. On review of these records inspectors noted that the majority of records were in relation to injuries of staff members from residents. In the month of January 2017 there had been 15 records of injuries to staff from residents. Some of these injuries had required staff to take time off work. One of these incidents required the assistance of the Gardaí to deal with a fight between residents that had resulted in long term absence of a staff member and pending criminal charges against a resident. Incidents between residents and staff were often witnessed or heard by other residents. The provision of one to one staff was one of the control measures identified to control aggression and violence. However, this was not always affective at doing this and still resulted in peer to peer altercations and injuries to staff.

Overall, inspectors found that the practices in the centre required addressing in order to fully promote the health and safety of residents, staff and visitors.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors were seriously concerned regarding the mechanisms in place to protect residents from harm or abuse.

Inspectors found that a concern of abuse witnessed by a staff member had been reported to the person in charge in December 2016. The person in charge failed to adequately respond to this concern, and did not adhere to both the provider's and national policy on the protection and welfare of children. This had resulted in the staff member continuing to work with vulnerable adults and children for a period of two weeks, until further information came to light which commenced an investigation. The person in charge admitted error in this regard. Inspectors were concerned that there were barriers in the reporting of concerns or allegations of harm or abuse. For example, three staff witnessed the incident of concern and only one staff spoke up to the person in charge.

Similarly the written reports of this particular incident did not outline or indicate any concerns or include the full information of what is alleged to have happened. The failure of the person in charge to adequately address the concern in line with national policy, did not result in staff taking alternative measures to ensure residents' safety. Inspectors were concerned that staff had not of spoken up, or reporting concerns about fellow staff or management in the centre in respect of concerns or suspicions of abuse or conduct. The provider had failed to ensure effective mechanisms were in place to safeguard residents, and to ensure there were no barriers to staff raising concerns if they felt their concerns had not been properly managed by the person in charge.

At the time of the inspection, there had been 30 notifications submitted to HIQA of an allegation, suspicion or concern of abuse since the centre had been opened in October 2015. Three of these were allegations against staff members, and 23 were in relation to peer to peer abuse or assaults. While inspectors were informed that safeguarding plans were in place to protect residents from their peers, inspectors were concerned that these were ineffective due to the on-going and repetitive incidents occurring. Some residents told inspectors that they did not feel safe living in the centre. Inspectors were concerned that the mechanisms for assessing risks and managing residents' safety were not robust.

Policies, practices and procedures required review to ensure residents' safety. For example, the policy on Child protection did not include clear timeframes or responsibilities beyond the reporting to Túsla. There was little information to show that when an allegation was against a staff member, that Trust in Care national guidance was adhered to and a clear process followed. The person in charge could not evidence if a preliminary screening had been done to inform the need for a full investigation, and there was no risk assessments completed on the child resident to determine any additional protective measures necessary in line with the provider's own policy. Safeguarding mechanisms were in need of substantial address by the provider.

Use of restrictive interventions:

Overall inspectors noted both good and poor practice in relation to the use of restraint in the centre.

For residents who had lived in the centre for a number of months, inspectors evidenced some good practices in relation to the use of restrictive interventions. For example, inspectors noted for a resident who had five incidents of assaultive behaviour in the month of January, only one of these incidents resulted in the use of a physical hold as an intervention. Alternative measures had been affective at deescalating the situation. However, in contrast, the process for new residents being admitted to the centre required improvements to ensure good and safe practice in relation to the use of restraint. For example, a new resident had not been assessed for, informed or consent given to the use of physical holds. The appropriateness of this intervention had not been risk assessed prior to a hold being used. The provider could not demonstrate that all measures were consistently exhausted prior to a restrictive intervention being used in line with the regulations.

The use of physical restraint and chemical intervention was used in the designated centre. Inspectors noted that as required (p.r.n) medicine was prescribed to a resident and that this was frequently used in the first number of days the resident had moved in. Some of the recorded reasons for its use were described as due to the resident being “aggressive and uncooperative towards staff”. Inspectors noted this was medicine was administered in line with the written prescription which noted its use as "for aggression".

The management team outlined that chemical restraints were not in use in the centre, and that antipsychotic as required (p.r.n)medicine prescribed was for the treatment of a mental health condition. That being said, inspectors noted the use of such medicine to handle situations that had escalated without clear descriptive guidance on when it should be used. For example, to be administered in event of "decompensation". However, for this resident there was no guidance for staff on how the resident demonstrates this. Inspectors discussed this with staff and found that there was no evidence of a written guidance or plan in this regard. For example, there was an absence of an anxiety management plan, a mental health relapse plan, a risk assessment, standard operating procedure or details within the personal plan. Inspectors also noted that this resident did not have a behaviour support plan even though she demonstrated behaviours of concern such as aggression and violence.

Inspectors were concerned that environmental factors were not fully considered as a

possible cause for the deterioration of residents' mental health. Evidence gathered showed that a resident had been admitted into the centre and assessed in February 2016 by psychiatry and psychology as being of stable mental health, with no suicidal or homicidal tendencies. No behaviour support plan was drawn up as the resident did not demonstrate any behaviours of concern and plans were in place to support the resident to move to more independent living environment. At the time of inspection, the resident had lived in the centre for a year and was demonstrating behaviours since the summer that had resulted in injury to fellow residents and staff. Inspectors were informed by the person in charge that the resident began demonstrating these behaviours and anxiety around waiting as they did not want to continue to live in the centre, and had not been fully informed of their future plans and timescales for a move to a different setting as they were reliant on another provider. Antipsychotic (p.r.n) medicine was being used to support the resident at times of escalation. Psychological assessments completed in June 2016 outlined the need for the resident to be informed of clear timescales for their transition to assist with this. The person in charge told inspectors that a timescale was agreed upon in January of 2017 for the resident to move in March, and since this time he felt there had been a reduction in the use of as required (p.r.n) and incidents in general.

The management of behaviours:

Inspectors found there to be good access to psychiatry and psychology services along with behaviour support. For residents who displayed behaviours of concern, functional analysis was carried out during the 12 week initial period of admission to determine possible causes. This resulted in a multi-elemental behaviour support plan (MEBPS) being put in place to show both proactive and reactive strategies to manage them. On review of a sample of some of these plans inspectors found that they were assisting some residents to positively manage behaviours. However, not all residents had a plan put in place even when behaviours had developed.

Training of staff:

Inspectors were informed that some of the online learning modules included information on Children First, but not all staff were clear that they had completed this. The person in charge had identified a need for all staff to receive Children First training at the time a child resident was being admitted in December. At the time of the inspection this additional training had not yet been provided. Following on from the inspection, the person in charge informed inspectors that dates had been set in March for this to be delivered to staff.

Staff had received online training in the protection of vulnerable adults and safeguarding. The Director of Operations had also covered this again at team meetings in the centre. Staff had all received training in the management of actual and potential aggression and records and staff both confirmed this was the case.

Judgment:
Non Compliant - Major

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Overall residents' healthcare needs were met in line with their personal plans and assessments.

Improvements were required under this outcome, as two of the residents did not have a general practitioner (G.P) assigned to them locally and adequate monitoring records relating to a specific heath condition were not being maintained for a residents who required them.

Residents' health needs were assessed on admission and met by the care provided in the centre. Four out of six of the residents had their own accessible general practitioner. There was evidence that all residents had access to a local out-of-hours doctors service. Inspectors reviewed up-to-date hospital passports on file for a sample of files reviewed. These provided a good level of detail to guide hospital staff should a resident need to be transferred to hospital. All of the residents had access to allied health care services which reflected their care needs. A log was maintained of residents' contact with their G.P and any other health professionals. There was evidence of multidisciplinary team involvement.

The centre had a fully equipped kitchen and a dining area. A balanced and varied diet was provided to the residents and a range of snacks were available in the centre. There was a nutrition policy in place. Inspectors observed residents choosing the snacks and meals they wanted and assisting staff to prepare same. Residents who spoke with inspectors said that they enjoyed the meals cooked for them in the centre, and residents were seen assisting in the food preparation over the course of the inspection.

Judgment:
Substantially Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were systems in place to ensure the safe management and administration of medicine. However, some improvements were required in relation to the administration of 'as required' p.r.n medicine.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines. The processes in place for the handling of medicines were safe and in accordance with current guidelines and legislation. There was a secure press for the storage of all medicines. Staff interviewed had a good knowledge of appropriate medication management practices and medications were administered as prescribed. Staff had received training in the safe administration of medicine which included competency exercises.

The inspector reviewed a sample of prescription and drug administration sheets and found that overall they contained the required information. However, the inspectors identified that as required (p.r.n) medicine were not always administered in line with the provider's policy. It required that the administration of such medicine was pre-authorised by the person in charge or manager on call. In a number of cases this was not always recorded as having occurred.

There were appropriate procedures in place for the handling and disposal of unused and out of date medicine, whereby they were returned to the pharmacy who signed off with staff receipt of same.

There was a system in place to review and monitor safe medication management practices. The inspector found that audits of medication management arrangements were undertaken on a regular basis and where issues were identified appropriate actions had been taken. A self medication assessment had been completed for a number of the service users regarding their competency to self medicate and the supports required to assist them.

Judgment:
Substantially Compliant

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors found that the description of the written statement of purpose did not accurately reflect what was provided. Inspectors discussed this with the person in charge and requested the most recent version of the statement of purpose to be submitted following on from the inspection and this was completed.

However, on review of the most up to date version inspectors found that there were still differences between what the written document and what the centre was actually catering for. For example:

- The centre was providing care and support for residents' mental health needs as well as intellectual disability and autism. This was not outlined in the statement of purpose.
- The statement of purpose did not include information on the arrangements for contact between residents and their representatives such as appointed social workers or after care workers.

Judgment:
Substantially Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors were concerned that there was an absence of effective governance in place to ensure a safe and good quality service.

There was a management structure in place, with lines of accountability and responsibility. However, inspectors evidenced that the roles and responsibilities of the management structure were unclear in relation to the regulatory responsibility of the person in charge and the provider. For example, the person in charge did not have clear

oversight on all safeguarding concerns or investigations in relation to the centre he was responsible for.

Systems that were in place were not robust in capturing the issues identified in this report, and did not adequately reflect the issues regarding safeguarding of residents, the management of risks and the protection of residents through the admissions process. Information reviewed in the annual review and unannounced visits by the provider for 2016 did not correlate with inspectors' findings and information received. For example, the annual review outlined a number of complaints from residents that could meet the criteria of allegations of abuse that had not been managed as such or notified to HIQA. Similarly in light of on-going peer to peer assaults and issues since the centre opened, the provider's audits and reviews found no actions in need of address in relation to safeguarding and safety.

Inspectors found that there was a system of supervision in place in the centre. The person in charge outlined that not all supervision that took place was formalised and recorded. While a system was in place, inspectors found that it did not fully ensure that staff exercised their own responsibility for the quality and safety of the care and support provided to residents. For example, their responsibility to speak up and raise concerns about practice, or the management of issues.

Judgment:
Non Compliant - Major

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There were appropriate staff numbers and skill mix to meet the assessed needs of the service users living in the centre. However, supervision and staff training arrangements required some improvements.

The staffing levels and skill mix were sufficient to meet the needs of the service users living in the centre. There was an actual and planned staff roster in place. There were no formal dependency levels established in the centre but inspectors noted that staffing levels had been increased on a number of occasions based on the person in charge's

informal assessment, in order to meet resident's needs. In the preceding four month period, a large number of new staff had commenced work in the centre. The residents appeared to have adjusted well to these changes. Four of the staff team did not have a formal qualification but three of them were working towards attaining a qualification.

There was a staff training and development policy in place. A training programme was in place and coordinated by the provider's training department. Training records showed that the majority of staff were up to date with mandatory training requirements. Computer based training modules were provided on a number of topics, including for protection and welfare of vulnerable adults and children, fire safety and basic first aid. Inspectors proposed that refresher training regarding mental health issues, autism and disability sign language should be considered. Staff interviewed were knowledgeable about policies and procedures in place. The inspectors observed that a copy of the standards and regulations were available in the centre. Staff spoke respectfully of residents and their needs and interactions were positive and familiar with residents. Both the person in charge and staff members appeared to have good relationships with the residents living in the centre.

There were staff supervision arrangements in place, whereby all staff were supervised by either the person in charge or one of the two deputy team leaders. However, there was no schedule in place and staff could be supervised by any one of the three afore mentioned. Inspectors reviewed supervision records for four members of staff and found that they were of an adequate quality. However, supervision for some members of staff was not being undertaken within the frequency proposed by the provider.
This meant that staff performance might not be effectively monitored to improve practice and accountability.

There were no volunteers working in the centre at the time of inspection.

Inspectors reviewed staff files and found that in general the requirements of Schedule 2 were in place. For example, proof of identity and Garda Vetting disclosures.

Judgment:
Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Louise Renwick
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Nua Healthcare Services Unlimited Company
Centre ID:	OSV-0005199
Date of Inspection:	31 January 2017 and 01 February 2017
Date of response:	20 April 2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Comprehensive assessments were not carried out prior to a move into the centre.

1. Action Required:
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
A comprehensive review of the admission process will be under taken to ensure that it meets all requirements of regulation.

Proposed Timescale: 15/05/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans put in place for new residents did not fully reflect their assessed needs until after a 12 week assessment was completed.

2. Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:
Residents personal plans to be reviewed and amended in line with regulation.

Proposed Timescale: 15/05/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The systems in place for assessing and managing risk were not adequate to ensure the health and safety of residents, staff and visitors.

3. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
PIC to review systems in place to review and manage all risks within the centre.

Proposed Timescale: 15/05/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The measures and actions to control aggression and violence were not effective.

4. Action Required:
Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

Please state the actions you have taken or are planning to take:
PIC will review all risk assessments and strategies which are in place to support with behaviours that challenge.

Proposed Timescale: 15/05/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Physical restraint was used on a child resident prior to it being risk assessed or agreed by a multidisciplinary team.

5. Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
PIC will ensure that strategies are in place for all residents should they display behaviours that challenge

Proposed Timescale: 15/05/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was inconsistencies in ensuring all efforts had been made to identify and alleviate residents' behaviour. Not all residents had a behaviour support plan even when displaying behaviours of concern.

6. Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are

considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
PIC will ensure that strategies are in place for all residents should they display behaviours that challenge

Proposed Timescale: 15/05/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Alternative measures were not consistently considered prior to the use of physical restraint. This was most evident for residents who had been newly admitted and restrictive practices not yet approved or assessed, but nonetheless used by staff.

7. Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
PIC will ensure that strategies are in place for all residents should they display behaviours that challenge

Proposed Timescale: 15/05/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider had not ensured all staff had received appropriate and adequate training in the national guidance on the protection and welfare of children.

Staff and management could not demonstrate a clear understanding of their duties within this national guidance.

8. Action Required:
Under Regulation 08 (8) you are required to: Ensure that where children are resident, staff receive training in relevant government guidance for the protection and welfare of children.

Please state the actions you have taken or are planning to take:
Further training will be completed with the staff team surrounding the National Guidance on the protection and welfare of children

Proposed Timescale: 15/05/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge failed to investigate a concern of alleged abuse raised by a staff member who witnessed a negative interaction between a staff member and a child resident.

9. Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
Further training will be provided to the PIC surrounding safeguarding.

Proposed Timescale: 15/04/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Due to the failure of the person in charge to investigate a concern of alleged abuse, residents were placed at risk of further harm and abuse.

Due to the nature in which the centre was operated and residents' admitted and assessed, the provider had failed to protect all residents from harm and abuse from their peers.

The provider had failed to ensure the policies, procedures and management systems were sufficient to protect all residents from harm or abuse.

10. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
The PIC and The Provider Nominee will ensure that there is a robust system implemented to ensure all allegations are dealt with in line with National Policy.

Proposed Timescale: 15/05/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Two of the residents did not have a general practitioner assigned locally.

Adequate monitoring records relating to a specific heath condition were not being maintained.

11. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
PIC to ensure that GP will be sourced locally and all health monitoring will be maintained.

Proposed Timescale: 15/05/2017

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors identified that PRN medications were not always administered in line with the providers policy.

12. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
A review of the guidelines for the administration of PRN medications to be completed

Proposed Timescale: 15/06/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The written statement of purpose did not clearly reflect on:

- the specific care and support needs the centre intended to meet. ie, mental health care needs and support
- The staffing titles and qualifications as is available in the centre
- the arrangements for contact between residents and their representatives, inclusive of social workers.

13. Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
The statement of purpose to be updated to reflect the information set out in schedule one of the Health Care Act.

Proposed Timescale: 15/05/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff had not raised concerns regarding the treatment of residents and the management of allegations.

14. Action Required:
Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Please state the actions you have taken or are planning to take:
A formal debrief will be completed with all members of staff within the centre to ensure compliance with safeguarding policies.

Proposed Timescale: 15/05/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management systems were ineffective at identifying areas of concern, and in ensuring the service was safe.

15. Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to

residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
Further training will be provided for the management structure within the designated centre

Proposed Timescale: 15/05/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Supervision arrangements of staff were not consistent.

16. Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
Supervision to be provided in line with the provider policies

Proposed Timescale: 15/04/2017